(J) Any other document, requested in writing by the Department, relating to the provision of services, the submission of claims for reimbursement or a facility's cost reports;

(K) Annual corporation report; and

(L) Federal income tax returns.

(iv) If any document is not submitted with the cost report, an explanation must be attached to the cost report and subsection (b) shall apply.

(v) Changes in a facility's reporting methods are permissible only when written application is received by the Department prior to the end of the cost report period. The Department shall approve the change if it can reasonably be expected to result in more accurate reporting.

(vi) Fiscal period. A provider shall adopt the same fiscal period for completing the cost report as the facility uses for reporting Medicare costs.

(A) If a provider that is certified by both Medicaid and Medicare does not use the Medicare fiscal year for reporting Medicaid costs as of the effective date of this Chapter, it must file a Medicaid cost report for the facility's first Medicare cost reporting period that ends on or after the effective date of this Chapter.

(B) If a provider is not certified by Medicare, the facility's Medicaid cost reporting period shall be the same period the facility uses for federal income tax reporting.

(C) Normally, a fiscal period will be twelve months in length. It may be less than twelve months because of changes in the facility's Medicare cost reporting period.

(d) Certification of cost reports.

(i) General requirement. The provider must certify the accuracy and validity of the cost report.

(ii) Who may certify. Certification must be made by a person authorized by the governing body of the facility to make such certification. Proof of such authorization shall be furnished upon request by the Department.

(A) If the provider is a corporation, an officer of the corporation must certify;

(B) If the provider is a general or limited partnership, a general partner must certify;

(C) If the provider is a sole proprietorship or sole owner, the owner must certify;

(D) If the provider is a public facility, the chief administrative officer of the facility must certify; or

(E) If the provider is some other entity, the person certifying must be approved in writing by the Department before the certification.

(iii) Certification statement. The cost report must contain the following certification statement:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.
>
> I hereby certify that I have read the above statement and I have examined the accompanying cost report and supporting schedules prepared by _____ (Provider name and number) _____ for the cost report beginning _____, 20__, and ending _____, 20__, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.
>
> _____ _____ _____
> Signature Title Date

(e) Substitute cost report forms. If a facility desires to submit its cost report on forms other than those specified by the Department, the facility must submit such substitute forms to the Department in advance of their use for prior approval. To be approved, such forms must be accompanied by a letter which represents that each page of the substitute form is the same size and has the same general appearance as the Department's cost report and that all form and data elements are present and appear in the same location and sequence on each page as on the Department's cost report. If approved, the Department shall issue an approval letter. Each use of substitute forms shall require a reference to the date of the Department's approval letter and indicate the substitute form's sponsor.

Section 6. Joint Use of Resources.

(a) Multiple business enterprises. If a provider owns, controls or manages multiple business enterprises, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable. If a field audit or desk review establishes that the provider's records do not clearly identify the information required by this Attachment, none of the commingled cost shall be an allowable cost for purposes of the facility's per diem rate.

(b) Control, ownership or management by third party.

(i) Separate records. When the facility is owned, controlled or managed by a person or entity that owns, controls or manages one or more other nursing facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities.

(ii) Allocation of pooled costs shall be reasonable and conform to GAAP, the provisions of this Attachment, and the instructions of the Department. Pooled cost is allowable only to the extent that the pooled cost is incurred in providing patient-related services and the provider can demonstrate that pooled cost improves efficiency, economy, or quality of care. All patient-related pooled costs allocated to a facility that meets these requirements shall be reported in the operating cost component.

(iii) Direct patient service costs. Direct patient service costs incurred by multiple facility organizations may be reported in the health care component if the service was rendered to the recipient at the facility and is separately identified, rather than allocated, in the provider's accounting records. Patient service costs which do not meet these criteria must be reported in the operating cost component.

Section 7. Per diem rate determination.

(a) New facilities.

(i) A new facility shall receive an initial rate determined pursuant to subsection 17(c).

(ii) A new facility's initial rate will be effective until the end of the first fiscal year ending six or more months after the certification date, at which time the Department shall establish a per diem rate pursuant to this Attachment.

(b) Change of ownership.

(i) A facility which has a change of ownership on or after August 1, 1992, shall receive the per diem rate in effect for that facility on the date of the change of ownership. This per diem rate shall remain in effect until the end of the first fiscal year ending six or more months after the date of the change of ownership, at which time the Department shall establish a per diem rate pursuant to this Attachment.

(ii) Record keeping requirements. The former owner shall be responsible for maintaining all medical and financial records for one year after the date of the change of ownership. If the facility is involved in an audit or administrative or judicial proceedings which require access to such records, the records must be maintained until the completion of all proceedings, including any applicable appeal periods.

(c) Other facilities. The per diem rate for all other facilities shall be established pursuant to the other provisions of this Attachment.

(d) Effective dates of per diem rates. Per diem rates are established prospectively and shall remain in effect from the rate effective date until redetermined pursuant to this Attachment.

Section 8. Medicaid allowable payment for nursing facility services.

(a) Per diem rate. The Department reimburses facilities providing nursing facility services to recipients using the per diem rates established pursuant to this Chapter.

(b) Reserved bed days.

(i) Facilities may receive the per diem rate for reserved bed days during temporary absences if an appropriate bed is not available during the time for which reimbursement is sought. For purposes of this section, "appropriate bed" means a bed in an empty room or a vacant bed in a room occupied by a person of the same sex as the temporarily absent recipient.

(ii) Reimbursement for temporary absences is limited to fourteen days per calendar year.

(iii) A provider may not bill a recipient or the recipient's family for reserved bed days that are not reimbursed pursuant to this section unless the facility has informed the recipient, in writing, before the period for which reimbursement is sought of the recipient's option to make payments to hold the bed if the temporary absence exceeds the period for which Medicaid reimbursement is available.

Section 9. Cost components.

(a) General requirement. Costs shall be allocated among the following cost components as specified in this section: (1) health care costs; (2) capital costs; and (3) operating costs. For purposes of this section, "labor costs" includes the cost of employee benefits and taxes.

(b) Health care cost component. The health care cost component consists of the following costs provided such costs are direct costs of patient-related services actually rendered within the facility (or direct patient-related services provided outside the facility if medically necessary) and the cost of related supplies actually used in the facility:

(i) Activities, including direct labor cost;

(ii) Dietary, including direct labor cost;

(iii) Direct health care labor costs for the following:

(A) Health care education, including OBRA '87 nurse aide training requirements;

(B) Licensed practical nurses;

(C) Medical director;

(D) Nurse assistants;

(E) Nursing administrators;

(F) Nursing consultants;

(G) Registered nurses; and

(H) Rehabilitation personnel.

(iv) Services and supplies included in the per diem rate (reduced by the cost of services paid from other sources); and

(v) Social services, including direct labor cost; and

(vi) Travel cost related to the above.

(c) Capital cost component. The capital cost component consists of the following costs:

(i) Leasehold amortization;

(ii) Rent/lease expense;

(iii) Depreciation; and

(iv) Interest on real estate and personal property.

(d) Operating cost component. The operating cost component consists of:

(i) Housekeeping, including direct labor;

(ii) Laundry, including direct labor cost;

(iii) Medical records;

(iv) OBRA '87 (The Omnibus Reconciliation Act of 1987, Pub. L. 100-203) compliance costs other than the cost of nurse aide training;

(v) Patient-related administrative costs (including home office and management fees which are not health care costs under subsection (b));

(vi) Plant operations and equipment costs; and

(vii) Travel costs related to the above.

Section 10. Determination of capital cost.

(a) Depreciation.

(i) The depreciation of a tangible asset used to deliver patient-related services is an allowable cost if the asset is:

(A) In use;

(B) Identifiable to patient care;

(C) Available for physical inspection; and

(D) Recorded in the provider's records.

(ii) Basis. The basis used in calculating depreciation shall be the historical cost of the asset.

(iii) Method. Depreciation must be reported on the straight line method.

(iv) Useful life. Useful life shall be determined in accordance with the most recent edition of Estimated Useful Lives of Depreciable Assets, as published by the American Hospital Association, which is hereby incorporated by reference.

(v) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least two (2) years and historical cost of at least five-hundred dollars ($500.00), the cost shall be depreciated over the useful life of the asset.

(vi) Patient-related items that do not qualify for the above definition shall be expenses in the year acquired.

(vii) Donated assets.

(A) Definition. An asset is donated to the extent the provider acquired the asset without paying fair market value in cash, property or services.

(B) Basis. The basis of donated assets, except for donations between providers or from a party related to the provider, is the asset's fair market value, minus the value the provider gave for the asset. If the fair market value of the asset is over $2,000.00, the basis shall be the lesser of the appraised value and the fair market value. If the donor is related to the provider, the basis shall be the lesser of the net book value of the donor and fair market value.

(C) Cash donations. Cash donations shall be treated as revenue, and not as an offset to expense accounts.

(b) Permanent Financing Interest.

(i) Allowable cost. Permanent financing interest incurred on patient-related real property, improvements to real property, buildings, building components and equipment is an allowable cost subject to the limitations of this subsection.

(ii) Maximum allowable interest rate. The allowable interest rate on permanent financing from a party related to the provider shall not exceed the Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family rate in effect on the date the loan commitment was signed by the lender and borrower.

(iii) Maximum allowable interest expense. The principal amount of permanent financing shall not exceed the allowable historical cost of the facilities and equipment.

(iv) Investment income offset. Interest allowable pursuant to this section must be reduced by investment income pursuant to the PRM.

(v) Reporting requirements. Interest expense must be supported by a written loan agreement, showing that funds were borrowed, payment of interest and repayment of principal is required, and funds were used to purchase patient-related real property, buildings, building components and equipment. The lender, purpose, principal amount, terms and interest rate must be identifiable in the provider's financial records.

(c) Lease and rental expense.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Maximum allowable. Leases, rental agreements, and contracts involving the use of real or personal property shall be subject to the same maximum capital component limit as owners of property.

(iii) Related parties. If a provider rents, leases or purchases patient-related real property, buildings, building components and equipment from a party related to the provider, the

historical cost to the related party, not to exceed fair market value, shall be utilized in computing the allowable capital cost.

(d) Amortization of leasehold improvements.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Amortization of leasehold improvements shall be calculated and reported in accordance with GAAP and are a capital cost.

(iii) Amortization of organizational cost shall be reported in the operating cost component.

Section 11. Determination of Operating Cost Component.

(a) Working capital interest.

(i) Generally. Interest on working capital loans is an allowable cost only if the loans were costs that must be incurred to provide patient-related services.

(ii) Limitation. Interest on working capital loans may not exceed the actual reported interest less any investment income revenue.

(iii) Reporting. Interest on working capital loans shall be reported as an operating cost.

(b) Compensation for services from owners or parties related to the provider.

(i) Compensation for services from an owner or a party related to the provider is an allowable cost if such services were:

(A) Actually performed;

(B) Necessary to the delivery of patient related services; and

(C) The compensation paid was reasonable.

(ii) Documentation. A provider must maintain written documentation of the time and work performed, the work's relationship to patient care, whether such work was performed at the facility or outside the facility, and the compensation paid for such work.

(iii) Maximum allowable. Compensation of an owner or party related to the provider is not an allowable cost to the extent it exceeds the median range for comparable services as contained in the most recent survey of administrative salaries paid to persons other than owners of proprietary and nonproprietary providers conducted by the Bureau of Health Insurance and published in the Medicare Provider Reimbursement Manual PRM Part 1, Section 905.2, which is hereby incorporated by reference.

(A) Part-time employees. For individuals who work less than a forty (40) hour work week, the maximum allowable amount shall be reduced by the ratio of actual number of hours worked per week to forty.

(B) Full-time employees. For individuals who work more than a forty (40) hour work week, either in one or more facilities, the allowable amount shall not exceed the median range in total, nor per facility. If the total hours worked by an individual in more than one facility exceed forty (40) hours per week, the allowable amount shall be prorated between the facilities.

Section 12. Cost of services and supplies not included in the per diem rate.

(a) The cost of services or supplies not included in the per diem rate shall be removed from patient-related cost.

(b) The method of removal depends on a provider's accounting and other records. If a provider has adequate segregation in accounting records, such adjustment shall be based on the cost of services or supplies not included in the per diem rate. If a provider does not maintain adequate cost segregation or if such accounts cannot reasonably be subjected to normal audit procedures, then the related revenue shall be used as an adjustment to patient expense, provided the related revenue amount is reasonably equal to or greater than cost. If these conditions are not met, the entire group of aggregated ancillary or other revenue accounts, or aggregated ancillary or other cost accounts, if greater, shall be used as an offset to patient expenses.

Section 13. Rate period.

(a) Effective date. A provider's per diem rate shall become effective on the rate effective date.

(b) Effective period of rate. A facility shall be bound by the per diem rate until a new rate is computed pursuant to this Attachment, unless the rate is changed as the result of a desk review or field audit.

(c) Determination of rates. The Department shall determine a facility's per diem rate by the first day of the fourth month after the month in which the Department receives the facility's cost report and all information required by section 5(c) (iii) (A-J), with the rate to be effective pursuant to Section 17.

(d) Notice of rate. The Department shall notify providers of the per diem rate by certified mail, return receipt requested.

Section 14. Creation of data base.

(a) Creation of data base. Each year the Department shall create a data base using the latest complete desk reviewed cost reports for each provider. "Latest complete" means that the cost report was used to compute the provider's most recent per diem rate and the rate was set by October 1, 1993, or by July 1 of the applicable year thereafter.

(b) Adjustment of cost reports. Cost reports included in the data base shall be adjusted so that transactions with owners or parties related to providers are limited pursuant to this Attachment. Per diem cost report information for the capital cost component shall be subject to a minimum occupancy of ninety percent (90%).

(c) Each year the Department shall create a data base which reflects the quality of care and the average level of care provided in facilities.

Section 15. Determination of medians.

(a) Median health care cost. Using the data base created pursuant to Section 14, the median health care cost shall be determined by arraying the inflation-adjusted allowable per-diem health care cost for each provider, from low to high and selecting the cost associated with the median licensed bed.

(b) Median operating cost. Using the data base created pursuant to Section 14, the median operating cost shall be determined by arraying the inflation-adjusted allowable per-diem operating cost for each provider, from low to high and selecting the cost associated with the median licensed bed.

(c) Median capital cost. Using the data base created pursuant to Section 14, the median capital cost shall be determined by arraying the inflation-adjusted allowable per-diem capital cost for each provider, from low to high and selecting the cost associated with the median licensed bed.

Section 16. Cost component limitations.

The Department shall, on or before December 1, 1993, and on or before September 1 thereafter, determine limitations for each cost component in accordance with this Attachment using the data base created pursuant to Section 14 and the medians determined pursuant to Section 15.

(a) Capital costs. Capital costs shall not exceed the maximum allowable as determined pursuant to Section 18.

(b) Health care costs. Health care costs shall not exceed 125 percent of the median health care cost.

(c) Operating costs. Operating costs shall not exceed 105 percent of median operating costs.

(d) Effective period of limitations. The cost component limitations shall be effective for rate effective dates from October 1, 1993, through June 30, 1994. Thereafter, cost component limitation shall be effective for rate effective dates from July 1 through June 30 of each subsequent year. Cost component limitations shall not be redetermined to reflect changes in facilities' allowable costs that result from reconsideration, administrative appeals or judicial decisions.

Section 17. Determination of per diem rate..

(a) Except as otherwise provided in this Chapter, the Division shall determine per diem rates to be effective for services furnished on or after May 1, 1996, as follows:

(i) Calculated rate. The Division shall establish a calculated per diem rate for each facility pursuant to this Chapter, using that facility's most recent Medicaid cost report for the period ending on or before December 31, 1995. The calculated rate will be the rate paid unless it is less than the minimum rate or greater than the maximum rate established pursuant to this subsection.

(ii) Minimum per diem rate. The Division shall establish a minimum per diem rate for each facility. The minimum per diem rate shall be the facility's base rate, minus the capital component of that rate, plus the capital component of the facility's calculated rate. The minimum rate shall be the rate paid if it is greater than the calculated rate.

(iv) Maximum per diem rate. The Division shall establish a maximum per diem rate for each facility. The maximum per diem rate shall be:

(A) The base rate, minus the capital component of that rate, multiplied by one-hundred ten (110%) percent of the inflation factor as measured from the mid-point of the base rate to the mid-point of the current rate period; plus

(B) The capital component of the calculated rate.

(C) The maximum rate shall be the rate paid if it is less than the calculated rate.

(b) Redetermination of per diem rates for rate effective dates after May 1, 1996. The Division shall redetermine each facility's per diem rate using that facility's cost reports for cost reporting periods ending on or after January 1, 1996, and annually thereafter, pursuant to and subject to the minimum and maximum rates established by subsection (a).

(c) New facilities. A new facility shall receive a per diem rate equal to 110 percent of the median per diem rate in effect as of the most recent July 1st, except that the capital component of the rate shall be the median allowable capital cost then in effect in Wyoming.

(d) Application of cost component limitations. The provider's reimbursable cost is the lesser of the provider's inflated allowable cost or the cost component limitations established pursuant to Section 16.

(e) Maximum per diem rate. A provider's per diem rate shall be the lesser of the rate determined pursuant to this Chapter or the facility's private pay rate.

(f) Except as otherwise specified in (b), a provider shall receive one rate change per year on the rate effective date, unless:

(i) The rate is changed as the result of a desk review or field audit; or

(ii) Changes in federal or state statutes or regulations cause increases in health care costs, as defined in subsection 9(b), or operating costs, as defined in subsection 9(d), in which case the Department shall determine whether and how to reimburse for such costs. Any changes pursuant to this paragraph shall be subject to the minimum and maximum rates established pursuant to subsection (a).

(g) Reconsideration. A provider may request that the Department reconsider a per diem rate pursuant to Section 32. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

Section 18. Determination of maximum allowable capital costs.

(a) The maximum capital basis per licensed bed shall be $28,500.00 as of January 1, 1989.

(b) Increase in maximum capital basis. The maximum capital basis shall be increased effective July 1 of each year by the lesser of one-half of the percentage increase in the Dodge Construction Index, which is hereby incorporated by reference, or one-half of the increase in the consumer price index. (If either the Dodge Construction Index or the consumer price index is discontinued, the Department shall use whichever index is available.) The increase shall be rounded to the nearest $100.00.

(c) Allowable maximum capital basis shall be limited to the maximum capital basis per licensed bed at the time of construction or January 1, 1989, whichever is later, of each bed plus one-half (½) of the difference between that amount and the maximum capital basis per bed at the rate effective date.

(d) For facilities constructed, acquired or leased prior to January 1, 1989, and facilities constructed after January 1, 1989, the capital component limitation shall be limited to the allowable maximum capital basis for each licensed bed times the average annual Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family rate rounded to the nearest half percent (.5%) divided by 90% of a facility's total available licensed beds times 365 days. The average annual

Federal Home Loan Mortgage Corporation Whole Loan Purchase, multi-family rate, shall be calculated as of January 1, 1989. This limit shall apply to all depreciation, interest, lease, rent, or other consideration paid for the use of property.

(e) For facilities acquired through purchase or a capital lease as defined by GAAP on or after January 1, 1989, the buyer/lessee's allowable historical cost of property shall be limited to the seller/lessor's acquisition cost increased by the lesser of one-half (½) of the percentage increase in the Dodge Construction Index, or one-half of the increase in the consumer price index. (If either the Dodge Construction Index or the consumer price index is discontinued, the Department shall use whichever index is available.) The maximum capital basis buyer/lessee shall be limited to the seller/lessor's maximum capital basis at the date of transaction. Any additional allowable capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had acquired the additional capital expenditure. For facilities leased through a lease determined not to be a capital lease in accordance with GAAP on or after January 1, 1989, the lessee's allowable capital component shall be limited to the lessor's capital component at the date of transaction. The maximum capital basis of the lessee shall be limited to the lessor's maximum capital basis at the date of transaction.

Section 19. Inflation adjustment.

A facility's allowable operating and allowable health care costs shall be inflated effective October 1, 1993, and each July 1 thereafter, using the annualized eight quarter average rate of change in the inflation factor. Cost components shall be inflated from the midpoint of the cost reporting period to the midpoint of the rate period as defined in Section 13.

Section 20. Incentive adjustment.

(a) Eligibility for incentive adjustment. A facility with allowable operating cost below the operating cost component limitations established pursuant to this Chapter shall be eligible for an incentive adjustment.

(b) Computation of incentive adjustment. The incentive adjustment shall be twenty-five percent of the difference between the facility's allowable operating cost and the operating cost component limitations. That amount shall be calculated on a per diem basis and added to the facility's inflation adjusted operating costs. The adjustment may not exceed $2.00 per day.

Section 21. Legislative Appropriations.

(a) If the Wyoming Legislature passes a special appropriation to be used to increase nursing facility reimbursement for any specific purpose defined by the Legislature in such appropriation, this section shall control the allocation of such appropriation among nursing facilities in Wyoming.

(b) The Department shall develop a methodology to allocate the appropriation among nursing facilities in Wyoming.

(i) The Department may consult with representatives of nursing homes, such as representatives of associations which represent nursing homes in Wyoming, about how to allocate the appropriation.

(ii) The Department shall collect the information it deems necessary to allocate the appropriation. The Department shall request information in writing, sent by certified mail, return receipt requested. Providers shall furnish the requested information in the format and according to the schedule established by the Department. All such information shall be submitted to the Department by certified mail, return receipt requested. Any information provided to the Department shall contain a certification statement substantially in the form specified in subsection 5(d).

(iii) After collecting information pursuant to paragraph (b)(i), the Department shall develop a methodology to distribute the appropriation among nursing facilities in Wyoming. The methodology shall:

(A) Effectuate the legislative purpose of the appropriation in a timely and cost-effective manner;

(B) Benefit Wyoming facilities equitably, such that no facility benefits disproportionately, based on the intent of the appropriation;

(C) Include safeguards to ensure that appropriated funds are spent for the purposes specified in the appropriation. Such safeguards shall include reporting and documentation requirements for facilities; and

(D) Specify how such funds shall be reported on facilities future cost reports, and whether and how such funds shall be considered in determining facilities future base rates and per diem rates.

(E) The Department shall disseminate the methodology to facilities through a Provider Manual or Provider Bulletin.

(c) Funds which are not spent for the purposes specified in the appropriation or pursuant to the methodology developed by the Department, and funds for which a facility cannot provide documentation as required by the Department, are excess payments and shall be recovered pursuant to Section 31.

(d) Any increase in a facility's per diem rate or other payment pursuant to this Section shall be subject to the cost component limitations of Section 16, and the maximum per diem rate established pursuant to Section 17, except as otherwise specified in the methodology developed pursuant to paragraph (b) of this Section.

Section 22. Reimbursement rate for extraordinary recipients.